January 16, 2020

INFORMATION MEMO FOR AMBASSADOR HEARNE, MOZAMBIQUE

FROM: S/GAC – Heather Watts, Chair and Eileen Wong, PPM

SUBJECT: Fiscal Year (FY) 2020 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly POARTS and from Headquarters Country Accountability and Support Teams, we have thoroughly reviewed progress of the program in your country over time and specifically the end of year results of the Country Operational Plan (COP) 2018 and current COP 2019 implementation as we plan for COP 2020. We have noted the following key successes and specific areas of concern:

Mozambique had a record year in the VMMC program, performing 390,498 VMMCs during the past year. Mozambique has improved targeted testing, greatly increasing index and key population testing, while also increasing identification yields during the past year. The cervical cancer program in Mozambique has also rapidly scaled up, screening 77,815 HIV-positive women during FY2019.

However, Mozambique has continued to be challenged by issues in case finding, retention, and treatment. In particular, Mozambique struggles with optimizing their identification of HIV-positive men and children to initiate treatment. Case finding among men has remained low and stagnant over the last few years. While the number of HIV-positive children identified has increased in FY2019, increased focus on testing children of all ages of index cases is necessary. Retention of patients on treatment continues to be a major issue; Mozambique ended FY2019 with a lower net new of patients on treatment than in the previous 3 years and increased their total on treatment by only 52,000 despite expending nearly $400 million. This suggests that previously identified retention and lack of treatment cohort growth issues were not adequately addressed during COP 2018 despite beginning AJUDA efforts and will need significant work during COP 2019 and COP 2020. Patients across all age groups and sexes were lost to follow up, but young men and young women pose the greatest challenge to Mozambique. Children and adolescents have lower levels of effective treatment coverage, leading to issues in viral load suppression, which may be improved as Mozambique implements policy changes away from NVP-based drug regimens.

SECTION 1: COP/ROP 2020 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2019 (EOFY) tool, and performance data, the total COP/ROP 2020 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency.

Table 1. COP 2020 Total Budget including Applied Pipeline

OU Total	Bilateral				Central	TOTAL
	FY20	FY19	FY17	Unspecified	Unspecified	TOTAL
Total New Funding	$370,045,183	$ -	$ -			$370,045,183
GHP-State	$366,970,183	$ -	$ -			$366,970,183
GHP-USAID	$ -	$ -	$ -			$ -
GAP	$ 3,075,000	$ -	$ -			$ 3,075,000
Total Applied Pipeline				$ 40,654,817	$ 1,500,000	$ 42,154,817
DOD				$ 84,151	$ -	$ 84,151
HHS/CDC				$ 31,222,132	$ -	$ 31,222,132
HHS/HRSA				$ -	$ -	$ -
PC				$ 549,266	$ -	$ 549,266
State				$ -	$ -	$ -
USAID				$ 8,799,268	$ 1,500,000	$ 10,299,268
TOTAL FUNDING	$370,045,183	$ -	$ -	$ 40,654,817	$ 1,500,000	$412,200,000

***Based on agency reported available pipeline from EOFY 2019.*

SECTION 2: COP 2020 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of $316,000,000 and the full Orphans and Vulnerable Children (OVC) level of $47,150,000 from Part 1 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

Table 2. COP 2020 Earmarks

Earmarks	COP 2020 Planning Level			
	FY20	FY19	FY17	Total
C&T	$270,000,000	$ -	$ -	$270,000,000
OVC	$ 33,500,000	$ -	$ -	$ 33,500,000
GBV	$ 3,287,967	$ -	$ -	$ 3,287,967
Water	$ 600,000	$ -	$ -	$ 600,000

** Countries should be programming to levels outlined in Part 1 of the COP 2020 Planning Level Letter. These earmark controls above represent the **minimum** amounts that must be programmed in the given appropriation year.*

Table 3. Total COP 2020 Initiative Funding

	COP 20 Total
Total Funding	**$116,500,000**
VMMC	$ 14,500,000
Cervical Cancer	$ 5,500,000
DREAMS	$ 35,000,000
HBCU Tx	$ -
COP 19 Performance	$ 48,000,000
HKID Requirement	$ 13,500,000

***See Appendix 1 for detailed budgetary requirements and other budgetary considerations.*

SECTION 3: PAST PERFORMANCE – COP 2018 Review

Table 4. COP OU Level FY19 Program Results (COP18) and FY20 Targets (COP19)

Indicator	FY19 result (COP18)	FY20 target (COP19)
TX Current Adults	**1,030,922**	**1,691,878**
TX Current Peds	**67,555**	**139,355**
VMMC among males 15 years or older	**192,675**	**249,397**
PrEP	**3,504**	**8,514**
DREAMS	**5,423 (8.4% of AGYW reached)**	**N/A**
Cervical Cancer	**77,815**	**210,993**
TB Preventive Therapy	**49,739**	**482,722**
TB Treatment of HIV Positive	**10,136**	**N/A**

Table 5. COP 2018 | FY 2019 Agency-level Outlays versus Approved Budget

OU/Agency	Sum of Approved COP/ROP 2018 Planning Level	Sum of Total FY 2019 Outlays	Sum of Over/Under Outlays
OU	**$399,885,000**	**$353,947,210**	**$45,937,790**
DOD	$8,422,116	$3,986,689	$4,435,427
HHS/CDC	$193,186,153	$172,323,926	$20,862,227
HHS/HRSA	$5,911,479	$4,684,640	$1,266,839
PC	$3,320,683	$2,465,036	$855,647
State	$2,459,653	$1,042,266	$1,417,387
State/AF	$773,000	$784,619	$(11,619)
State/SGAC	--	--	--

USAID	$180,111,916	$168,400,035	$11,711,881

Table 6. COP 2018 | FY 2019 Implementing Partner-level Outlays versus Approved Budget

Mech ID	Prime Partner	Funding Agency	COP/ROP18/FY19 Budget (New funding + Pipeline + Central)	Actual FY19 Outlays ($)	Over/Under FY19 Outlays (Actual $ - Total COP/ROP18 Budget $)
17567	National Alliance of State	HHS/CDC	369,945	412,274	42,329
9564	American Society of Clinical Pathology	HHS/CDC	1,755,440	2,166,234	410,794
12619	American Association of Blood Banks, Inc.	HHS/CDC	262,482	334,697	72,215
13661	Fundacion Privada Instituto De Salud Global Barcelona	HHS/CDC	300,000	468,323	168,323
70209	Direccao Provincial de Saude de Tete	USAID	512,905	600,000	87,095
18336	Catholic Relief Services – United States Conference of Catholic Bishops	USAID	390,000	460,641	70,641
18367	Right to Care	USAID	917,411	1,120,451	203,040
17652	University of California	USAID	250,000	499,352	249,352
14748	United Nations Children's Fund	USAID	500,000	1,727,671	1,227,671

Table 7. COP 2018 | FY 2019 Results & Expenditures

Agency	Indicator	FY19 Target	FY19 Result	% Achievement	Program Classification	FY19 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	5,054,153	**5,660,981**	112%	HTS Program Area	17,678,582	56%
	HTS_TST_POS	318,437	**242,438**	76.1%			
	TX_NEW	300,767	**214,648**	71.4%	C&T Program Area	85,693,234	37%
	TX_CURR	1,132,848	**874,227**	77.2%			
	VMMC_CIRC	268,095	**222,887**	83.1%	VMMC Subprogram of PREV	17,030,140	71%
DOD	HTS_TST	117,652	**127,877**	108.7%	HTS Program Area	606,857	100%
	HTS_TST_POS	6,852	**5,960**	87.0%			
	TX_NEW	5,635	**4,969**	88.2%	C&T Program Area	3,502,433	100%
	TX_CURR	17,295	**16,323**	94.4%			
	VMMC_CIRC	34,343	**38,727**	112.8%	VMMC Subprogram of PREV	1,715,676	100%
USAID	HTS_TST	2,206,822	**2,274,828**	103.1%	HTS Program Area	14,259,605	92%
	HTS_TST_POS	134,956	**91,179**	67.6%			
	TX_NEW	115,160	**70,523**	61.2%	C&T Program Area	83,678,018	82%
	TX_CURR	438,370	**269,085**	61.4%			

VMMC_CIRC	128,548	**128,884**	100.3%	VMMC Subprogram of PREV	9,982,544	93%
OVC_SERV	476,374	**473,978**	99.5%	OVC Major Beneficiary	14,922,172	59%
				Above Site Programs	27,509,778	
				Program Management	60,114,530	

COP 2018 | FY 2019 Analysis of Performance

We commend Mozambique for a number of achievements during FY 2019. The prevention program in Mozambique has been efficient and successful; the VMMC program achieved a record number of 390,498 VMMCs while staying within budget. Mozambique has worked hard to improve the efficiency of their case identification. Targeted testing using index cases and among key populations have greatly increased in number and yield of case identification. Mozambique has also worked hard to implement strong programs to prevent other associated preventable disease, scaling up the cervical cancer program and screening 77,815 HIV-positive women during FY2019.

We recognize all of the hard work that the Mozambique field team and partners have done over the past 16 years, and particularly this past year to continue this program at such a large scale. Mozambique has continued to be challenged by critical issues in case finding, retention, and treatment. An estimated 2.2 million PLHIV are in Mozambique, with only 52% of PLHIV currently on treatment. While we acknowledge that two major cyclones disrupted services and destroyed critical infrastructure, thanks to your effort, patients were quickly recovered and put back on treatment by FY2019 Q3 and Q4. In FY2019, case finding continued to be problematic; all agencies exceeded their testing target but only reached 67-87% of the positive target. Mozambique has improved their index testing, but they still struggle with identifying HIV-positive men and children to initiate treatment. Identification of men has remained stagnant over the years, but particularly needs to be improved in male partners of pregnant women. The case identification of children greatly improved in FY2019, but problematic policies surrounding index case testing of children of PLHIV ages 10-14 were identified as well. Implementation of policy changes to test all children of PLHIV need to be implemented immediately. Mozambique continues to have issues with retaining patients on treatment, a problem that has been identified year after year of the program. Mozambique did not meet its targets for PLHIV on current treatment and ended FY2019 with a lower net new of patients on treatment than in the previous 3 years despite a larger budget. Despite renewed efforts with AJUDA close supervision of sites and patients, retention and lack of net new patient issues have continued into FY2019, and will need be addressed during COP 2019 and COP 2020. Although patients across all age groups and sexes were lost to follow up, renewed efforts will need to focus on the largest groups lost to follow up - young men age 20-34 and young women ages 15-29. Children and adolescents who have been identified as HIV-positive have had less effective treatment coverage, leading to lower viral load suppression. As Mozambique continues to transition from NVP to DTG-based drug regimens during FY2019 into FY2020, the low viral load suppression in children should improve.

Care and Treatment

- Mozambique continues to have problems with their retention of PLHIV on treatment, an issue that has been ongoing for the past few years. Year over year, they have not reached their treatment current targets, achieving 73% of their TX_CURR target at the end of FY2019, leaving many PLHIV untreated, at risk of death and allowing ongoing transmission. They had a smaller increase in new patients (TX_NET_NEW) in FY2019 compared to the previous 3 years. This issue is evident across all provinces and populations by age and sex, but is particularly problematic for the large groups of young men and women who are not kept on treatment.
    - Between FY2018 Q4 and FY2019 Q4, the percentage of males 15+ years on treatment in Mozambique decreased by 5%. In addition, in the first three quarters of FY2019, half the number of men were put on treatment compared to women ages 15+ years. UNAIDS 2019 data shows significant gaps in the 1st 90 (61%) and 2nd 90 (42%) among males 15+ years in Mozambique. Therefore, in COP20, Mozambique should focus on finding and reaching HIV+ men (specifically within the 25-34 year age band), adding them to treatment, and attaining viral suppression among this group.
- Although Mozambique had 98% linkage of HIV-positive pregnant women to ART, there continues to be poor viral load coverage with no province reaching 90% coverage, and even worse suppression of VL in pregnant women (ranging from 11-48%) across all provinces. This has prevented the vertical transmission rate from rapidly decreasing, remaining at 4.5-5.6% during FY2019. Nampula and Zambezia, the provinces with the highest <12 month EID positivity, showed promising downward trends over the course of FY 2019.
- Viral load coverage and suppression in PLHIV on treatment are slowly improving from last year, with 54% viral load coverage and 80% viral load suppression in FY2019. No provinces achieved 90% suppression.
- Viral load suppression in children and adolescents (0-19 years) is alarmingly low, at only 53% VLS at the end of FY 2019.

Partner Performance

- JHPIEGO, funded by DoD, has met their TX_CURR targets, but could improve viral load suppression and retention of new patients (TX_NEW > TX_NET_NEW). JHPIEGO expended 109% of their budget for FY 2019.
- EGPAF, funded by CDC, underperformed in retaining patients on treatment (TX_CURR and TX_NET_NEW) and viral load suppression. However, they have greatly increased their net new of patients during FY 2019. EGPAF expended 99.34% of their budget.
- CCS, funded by CDC, achieved above TX_NEW targets, but underperformed in TX_CURR and viral load suppression. They continue to struggle with retention and increasing TX_NET_NEW, but have improved since FY 2018. They pivoted out of Inhambane during FY 2019 to focus on supporting Maputo City only. CCS expended 98.06% of their budget.

- ICAP, funded by CDC, achieved TX_NEW targets, but underperformed in TX_CURR, TX_NET_NEW, and viral load suppression. ICAP lost many patients at the beginning of FY 2019 due to DQA and data discrepancy while pivoting out of Zambezia to focus on supporting Nampula only. ICAP had leadership and organizational change in FY 2019 to address previous year issues. Although they were able to steadily increase TX_NET_NEW during FY 2019 Q2-Q4, their performance did not reach their quarterly net new from FY 2018 quarters and they had a negative net new for FY 2019. ICAP expended 85.93% of their budget.
- ARIEL, funded by CDC, steadily increased their TX_NET_NEW over FY 2019 after a negative start to FY 2018. However, they underperformed in TX_NEW, TX_CURR, and viral load suppression while expending all of their budget (99.94%) for FY 2019.
- FGH, funded by CDC, greatly increased their TX_NET_NEW, but underachieved in TX_CURR, TX_NEW, and viral load suppression. FGH expended 98.22% of their budget.
- CHASS, funded by USAID, underperformed in retention and viral load suppression while overexpending their budget (106%). However, they were replaced during FY2019 by new partner, ECHO, which has had promising early numbers.

Case Finding

- While Mozambique has improved their targeted testing programs for index cases for adults (yield of 31% in adults at the end of FY 2019 Q4) and key populations (yield of 21% at the end of FY 2019 Q4), more work needs to be done to optimize their case finding for men and children.
    - Case finding of men has remained low and stagnant over the past few years. UNAIDS 2019 data shows significant gaps in the 1st 90 (61%) and 2nd 90 (42%) among males 15+ years in Mozambique. Therefore, in COP20, Mozambique should focus on finding and reaching HIV+ men (specifically within the 25-34 year age band), adding them to treatment, and attaining viral suppression among this group
    - The case finding of children overall improved in FY 2019, but children 10-14 years of age were not included in index testing and were not started on treatment early enough.
- Mozambique was guided to decrease non-targeted testing to increase focus on retention during FY2019. However, they continue to have high numbers of tests (over 8 million tests in FY2019), with low positive case finding yields (4.21% in FY 2019), lower than in previous years.

Partner Performance

- CCS, ICAP, and FGH, funded by CDC, achieved case identification targets.
- JHPIEGO, funded by DoD, underperformed in case identification targets, yet tested 400% over their target HTS_TST.
- EGPAF and ARIEL, funded by CDC, underperformed in case identification targets.

- CHASS, funded by USAID, underperformed in case identification targets. However, they were replaced during FY2019 by new partner, ECHO, which has had promising early numbers.
- FHI, funded by USAID for KP activities, achieved case identification targets.

OVC

- We commend Mozambique for increasing their focus on OVC pediatric services, increasing enrollment and achieving 100% of the <18 OVC_SERV target, with 10-14 year olds making up the majority of the OVC program. The OVC_HIVSTAT known status proxy for FY19 in Mozambique was 80% of those <18, and will need to reach 90% according to COP 20 guidelines. Neither program has met their targets in graduating children from the OVC program.

Partner Performance

- FHI 360's CoVIDA and WEI, funded by USAID, achieved OVC_SERV and OVC_HIVSTAT targets. FHI expended 99% of their budget and WEI expended 96% of their budget.
- PeaceCorps underperformed in their OVC targets and expended 98% of their budget.

DREAMS

- The DREAMS program struggles with package completion, although Xai-Xai had the highest graduation rate at 54%. We look forward to the effects of continued implementation of layering tool, unique ID for tracking, improved data quality, and expanding the successes of the Xai-Xai program to other provinces.

VMMC

- We commend Mozambique for their record year in the VMMC program, performing 390,498 VMMCs during the past year. About half of these VMMCs were done on men 15+.

Partner Performance

- JHPIEGO, funded by DoD, achieved and surpassed VMMC targets, although JHPIEGO funded by CDC did not achieve VMMC targets. JHPIEGO, funded by DoD, expended 69% of their budget and JHPIEGO, funded by CDC, expended 107% of their budget.
- JSI, funded by USAID, achieved VMMC targets. JSI expended 77% of their budget.
- ICAP, funded by CDC, underperformed in VMMC targets. ICAP expended 86% of their budget.

Above-Site

- PEPFAR Mozambique has invested heavily over the years in health information systems, supply chain, laboratory infrastructure, and work force training. Current investments should be scrutinized carefully to determine performance versus benchmarks and remaining gaps. As outlined below, the private sector should be tapped to provide supply chain and laboratory specimen transport support to increase efficiency.

- The team should work closely with MISAU and CNCS to develop strategies to increase patient literacy and decrease stigma and discrimination.
- The team should coordinate closely in development of the Global Fund concept note to assure that key priorities are adequately funded**.**
- The team should focus above-site activities toward helping retention activities.

Most partners expended nearly all of their budgets for FY 2019, yet none of them achieved all of their targets. All partners could improve across most areas of the clinical cascade, but most could benefit from extrapolation of JHPIEGO's success in retaining current PLHIV on treatment. ARIEL underachieved across nearly all indicators despite expending their entire budget. ICAP struggled with recovering from their initial DQA and data discrepancy loss, but may be on the path to improvement with their focus on Nampula and organizational changes.

SECTION 4: COP 2020 DIRECTIVES

The following section has specific directives for COP 2020 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

Table 8. COP 2020 (FY 2021) Minimum Program Requirements

	Minimum Program Requirement	Status	Outstanding Issues Hindering Implementation
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	Test and start in place at all facilities.	Need to continue to increase linkage rate to reach 95% and assure immediate access of appropriate treatment for all age groups.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing	DTG transition in progress, circular released in November, 2019 for DTG as preferred therapy	Need to accelerate transition to DTG for established clients and to

[1] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

	>30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	above 20 kg and both sexes.	non-nevirapine regimens for children.
	3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	Three month dispensing has been implemented at 300 sites and is being expanded. MISAU committed to fast-track implementation of 6-month dispensing at these sites and at all PEPFAR sites by end of COP19.	Continue to work with MISAU to address issues limiting 6 month dispensation such as pharmacy computer systems and storage and assure availability of 90 and 180 pill bottles.
	4. All eligible PLHIV, including children, should have been offered TB preventive treatment (TPT) by end of COP20; cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	Scale up of TPT is in progress and cotrimoxazole is being provided.	Continue to scale TPT and assist with ordering of combination TPT/cotrim.

[2] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019
[3] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016
[4] Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	Diagnostic network optimization in process and nearly complete with good cooperation from TB program.	Headquarters to provide support as needed to complete optimization and assure rapid VL scaling.
Case Finding	6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	Index testing is being scaled with 23% of positives coming from index testing in Q4 of 2019. Partners elicited/index was 2.3 which is good. Numbers of children tested is increasing in age 10 and under.	Continue to scale index testing across all age groups. Recent MISAU policy change should increase testing in the 10-14 year old age group, but this needs to be monitored closely.
Prevention and OVC	7. Direct and immediate assessment for and offer of prevention services, including pre-exposure	PrEP targets increased from COP18 to COP19 but still remain low and geographically limited.	PrEP should be available in all provinces for those testing negative in index testing but remaining at risk, for key populations, and for at risk AGYW

[5] Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/

	prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]		identified through DREAMS. Assure policies are in place to allow widespread implementation of PrEP.
	8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) providing support and case management for	OVC_STAT was above 100% of target and was 80% of OVC_SERV under age 18. The enrollment of CLHIV into OVC programs is increasing but needs to expand. Service package is appropriate.	Continue to identify CLHIV on ART who are not enrolled into OVC to provide support, especially for those with unsuppressed VL.

[6] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

	vulnerable children and adolescents living with HIV 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.		
Policy & Public Health Systems Support	9. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	User fees have not been identified as a barrier in Mozambique.	N/A
	10. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP	The team works closely with MISAU to implement quality standards and evaluate sites.	Continue joint AJUDA visits to assess and improve quality of care and monitor IP performance.

[7] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

	work plans, Agency agreements, and national policy.[8]		
	11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	The team has been working with CNCS to increase community awareness and treatment literacy.	Mozambique has a diverse population with only about 50% of the population speaking Portuguese. Messaging needs to be done through multiple channels and must be translated into local languages.
	12. Clear evidence of agency progress toward local, indigenous partner prime funding.	The proportion of funding to local partners has been increasing each year. Recent large USAID award includes timeline for transition to local prime.	Continue to support capacity building of local partners to allow them to compete for awards.
	13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	The GoM provided $10 million for ARV's in COP19, in addition to support of the health care system.	Resources in country are limited but should be increasing with natural resource development in progress. Work with GoM to assure that health sector and HIV care benefit as the economy expands.

[8] Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

	14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	EPTS system in place at majority of PEPFAR sites.	Continue to enhance monitoring systems at PEPFAR sites to track outcomes. Need to improve community/facility linkages to track outcomes and return LTFU to care.
	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Mozambique has birth registration and a unique identifier system which was recently implemented for children. The team is working with the GoM to expand unique identifiers and improve monitoring.	Continue to work to expand unique ID's to allow better tracking of those on treatment.

In addition to meeting the minimum requirements outlined above, it is expected that Mozambique will:

Table 9. COP 2020 (FY 2021) Technical Directives

OU –Specific Directives
HIV Treatment
1. Scale index testing for adults and children; social network testing in high risk groups; increase partner testing for pregnant women
2. Optimized PITC especially for identifying older clients
3. Meeting clients where they are with what they need at each stage of the treatment cascade will be critical to advancing life-long continuity of ART. This requires a better understanding of client needs in order to remove barriers to treatment. MenStar is a coordinated effort to clearly understand obstacles to testing and treatment and differentiate service delivery for men. Leveraging the insights garnered through MenStar, and as a priority MenStar country, Mozambique should implement a core package of services that meet men where they are with what they need. Please see the newly released MenStar Guidance Document and Compendium for recommended strategies, interventions, and examples**.**
4. Continue with COP19 pivot: AJUDA and emphasis on site-level HRH support and client- and family-centered care. Use findings from AJUDA work to develop solutions to barriers, such as providing transportation vouchers for appointments, increased case management, etc.
5. Integrate youth and young adult case management and support groups for PLHIV 18-29 and increase enrollment of CLHIV into OVC programs
6. Develop strategic marketing approach to improve treatment literacy, and encourage "LTFU" and "Never Linked" to return to care. Engage community groups and faith community to improve treatment literacy.

7. Provide advanced disease package at regional hospitals; provide basic package for all to reduce OI's (Point of care CD4 at baseline, cotrim, TPT, early support models)
8. Maximize 6 month dispensation, consider 12 months for migrant workers
9. Introduce 3HP for TPT, continue to scale TPT broadly
10. Increased site level demand for viral load and results return, viral load champions at sites to increase identification of stable clients for 6 month dispensation
11. Integrate laboratory (DISA) and patient (EPTS) record systems to increase efficiency of results return
12. Scale successful mental health intervention from Sofala to additional sites to improve retention
13. Improve mentor mother supervision
14. Pediatric ART optimization
15. OVC and clinical implementing partners in Mozambique must work together to ensure that 90% or more of children and adolescents on ART with PEPFAR support in OVC SNUs are offered the opportunity to enroll in the comprehensive OVC program.
16. Increase VL capacity and coverage including POC VL for pregnant/BF women
HIV Prevention
1. Scale PrEP to all provinces for KP's, AGYW, serodiscordant couples, and ANC. Those testing negative in index testing who remain at high risk should be offered PrEP.
2. Expand demand creation to support VMMC age pivot
3. Link high risk AGYW to DREAMS; expand DREAMS districts based on HQ guidance and collaboration with GF
4. Increase mobile services for KP's; use IBBS results to target activities
Other Government Policy or Programming Changes Needed
1. Work with GF to increase condom stewardship and increase coverage of prevention activities for vulnerable AGYW
2. Continue to scale cervical cancer screening and treatment at screening sites, expand LEEP
3. Expand the outsourced medicines distribution system to the entire country to provide timely and cost effective last mile delivery
4. Consolidate the lab specimen transportation network under private sector management
5. Implement a vendor managed inventory approach for viral load reagents to improve availability of commodities and ensure VL platforms are maintained and functioning
6. Develop and implement decentralized distribution approaches, in addition to multimonth dispensing, to enhance convenience for clients and improve patient retention and adherence to ART
7. Engage with MISAU and CNCS on expanding treatment literacy, stigma reduction, partnerships with faith communities
8. Further improve/expand EPTS, iDART, and mHealth systems; improve data quality
9. Establish a data sharing agreement with GoM that allows for transparent discussion on site level and warehouse stock availability

COP 2020 Technical Priorities

Client and Family Centered Treatment Services

COP 2020 planning must specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous ART for a population that is often young and asymptomatic— and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are convenient and fit the lives of the clients, and make it easy for patients on ART to continue treatment. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient ARV pick-up arrangements, and community and client participation in design and evaluation of services. Mozambique must ensure 100% "known HIV status" for biological children of TX_CURR clients (15+), including chart review and retrospective elicitation of eligible biological children.

Community-led Monitoring

In COP 20, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador's small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

Pre-Exposure Prophylaxis (PrEP)

Groups to be prioritized for PrEP include those testing negative in index testing but remaining at increased risk of HIV acquisition by virtue of unprotected exposure to a PLHIV with unsuppressed viral load, key populations including sex workers, men who have sex with men, transgender persons, people who use drugs, adolescent girls and young women, including pregnant and breastfeeding women, in areas with high HIV incidence or with high risk partners, and other identified serodiscordant couples.

TB Preventive Treatment (TPT)

TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP20; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

DREAMS

DREAMS funding is allocated within your COP 2020 planning level and must be used exclusively for the goal of HIV Prevention among adolescent girls and young women (AGYW) in DREAMS SNUs in accordance with all DREAMS and COP 2020 Guidance. In addition to ensuring that all DREAMS beneficiaries complete the core package of relevant services, priorities for COP20 DREAMS implementation include: systematically identifying and engaging AGYW that are most vulnerable to HIV acquisition, improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities through PEPFAR), and accelerating PrEP uptake for AGYW.

DREAMS is receiving an increase in new funding which should be used for the following:

- **Interagency** expansion into new districts: The following 23 districts should receive new DREAMS funds for COP20. These districts have either an extremely high incidence (2.03 – 3.98%) and over 5,000 PLHIV or a very high incidence (1.2 -1.96%) and over 10,000 PLHIV, but have no DREAMS or Global Fund AGYW presence.

Country	DREAMS SNU	UNAIDS F15-24 Incidence Estimate	UNAIDS Incidence Classification	PLHIV (COP19 DataPack)
Mozambique	Montepuez	3.98	Extremely high	19,713
Mozambique	Luabo	3.06	Extremely high	7,553
Mozambique	Homoine	2.90	Extremely high	9,397
Mozambique	Inhassoro	2.87	Extremely high	6,390
Mozambique	Zavala	2.86	Extremely high	11,631
Mozambique	Moamba	2.57	Extremely high	16,556
Mozambique	Muidumbe	2.42	Extremely high	9,781
Mozambique	Mocimboa da Praia	2.40	Extremely high	11,440
Mozambique	Morrumbene	2.34	Extremely high	12,459
Mozambique	Mocubela	2.30	Extremely high	15,720
Mozambique	Balama	2.22	Extremely high	8,613
Mozambique	Maxixe	2.07	Extremely high	10,652
Mozambique	Mabalane	2.03	Extremely high	5,035
Mozambique	Magude	1.96	Very high	15,208
Mozambique	Guija	1.90	Very high	13,444
Mozambique	Namuno	1.78	Very high	13,318
Mozambique	Macomia	1.70	Very high	10,066
Mozambique	Vanduzi	1.56	Very high	14,273
Mozambique	Inhassunge	1.40	Very high	13,870
Mozambique	Caia	1.31	Very high	11,862
Mozambique	Kanyaka	1.21	Very high	23,894
Mozambique	Ancuabe	1.20	Very high	12,458
Mozambique	Chibabava	1.14	Very high	14,882

  - Note: The geographic expansion mentioned here is limited to NEW DREAMS funds. Any expansion within the existing DREAMS envelope is subject to the criteria laid out in COP20 guidance (i.e., must have reached saturation, must have shown progress via WAD modeling data, or some other data).
- STIs: Mozambique is one of the countries in which we would like to conduct STI testing and treatment. $133,000 of your new funds should be dedicated to STI testing and treatment. Further details on the number of AGYW that will likely need to be tested, the cost of testing and treatment for each type of STI, etc. will be provided.
- PrEP: Significantly scale-up PrEP for AGYW in all DREAMS districts.
- Partner Management: Urgent improvements are needed for the DREAMS layering database. Partner management must be improved to ensure data accuracy and full understanding of DREAMS implementation. If existing partners cannot track how their funds are used to implement DREAMS, then new partners should be enlisted.
- Minimum Requirements for new funds: To receive additional funds, Mozambique must present a strategy and a timeline at the COP meeting for the following:
  - Hire a deputy DREAMS Coordinator (100% LOE)

- Hire a DREAMS ambassador for each province to support DREAMS coordination and oversight
- Implement approved, evidence-based curricula in line with the current DREAMS Guidance
- Ensure a fully operable layering database with unique IDs across IPs and SNUs
- Ensure a full geographic footprint in all districts
- Address challenges and ensure DREAMS implementation in all districts with fidelity

OVC

To support the Minimum Program Requirement described above, in COP 20 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi-disciplinary care team and addressing key issues such as bi-directional referral protocols, case conferencing, shared confidentiality, and joint case identification. PEPFAR-supported treatment clinicians should play a key role in training OVC community case workers to build their knowledge in areas such as adherence, retention, and disclosure.

VMMC

Funds have been provided to conduct VMMC for males 15 years or older. The team is reminded of the revised guidance which allows surgical VMMC under the age of 15 only by the dorsal slit method and only for those who have attained Tanner stage 3 or higher of development and are able to provide full informed consent for the procedure. While Shang ring may be considered for those below age 15 regardless of Tanner stage, the same informed consent issues apply. All VMMC providers must adhere to the requirements for reporting of Notifiable Adverse Events.

Cervical Cancer Screening and Treatment:

Funding for cervical cancer screening and treatment of pre-invasive lesions. The target for screening must be equal to half of the TX_CURR for women age 25-49. All teams performing cervical cancer screening must adhere to the PEPFAR screening guidance. Basic treatment should be available for pre-cancerous lesions at the site of screening except under exceptional circumstances. All sites performing screening should establish clear referral mechanisms for patients needing treatment not available on site such as LEEP or evaluation for potential invasive cancer. Patient referral between sites should be facilitated and outcomes of the referral tracked to assure appropriate treatment and to allow reporting of results.

PLHIV Stigma Index 2.0

PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised Stigma Index 2.0, or complement Global Fund or other donors financing implementation of the Stigma Index 2.0, if it has not already been implemented in the OU. This revised U.S. government compliant version can begin the process of baseline data collection for evaluating the future impact of interventions on reducing stigma, and can inform future HIV program planning. If the revised Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 20, whether supported by PEPFAR or other resources.

COP 2020 Stakeholder Engagement (see section 2.5.3 of COP Guidance)

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP/ROP 2020 remains a requirement for all PEPFAR programs, and as such the COP/ROP 2020 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2019 Q4 and FY 2019 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2020 in order to introduce and discuss all COP/ROP 2020 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2020. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund New Funding requests with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2020, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Atlanta, GA where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Specific guidance for the 2020 meeting delegations have been provided elsewhere. Engagement with all stakeholders is required beyond the meetings and throughout the COP/ROP 2020 development and finalization process. As in COP/ROP 2019, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP/ROP 2020 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements

Table 11. COP 2020 New Funding Detailed Controls by Initiative

	COP 2020 Planning Level			
	FY20			COP 20 Total
	GHP-State	GHP-USAID	GAP	
Total New Funding	**$366,970,183**	**$ -**	**$ 3,075,000**	**$370,045,183**
Core Program	$305,470,183	$ -	$ 3,075,000	**$308,545,183**
COP19 Performance	$ 48,000,000			**$ 48,000,000**
HKID Requirement ++	$ 13,500,000			**$ 13,500,000**

++DREAMS countries with GHP-USAID funding can use FY20 GHP-USAID funding to meet their FY20 HKID Requirement. These countries include: Kenya; Nigeria; South Africa; Tanzania; Uganda; and Zambia

Care and Treatment: If there is no adjustment to the COP/ROP 2020 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment amount from Part 1 of the planning level letter across all funding sources. Additionally, due to Congressional earmarks, some of the care and treatment requirement must be programmed from specific funding sources, as indicated above in Table 2. Your care and treatment requirement for the purposes of Congressional earmarks is calculated as the sum of total new FY 2020 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS, HLAB budget codes, 80% of the total funding programmed to the MTCT budget code, and 50% of the total funding programmed to the HVCT budget code.

Orphans and Vulnerable Children (OVC): Countries must program to the full OVC amount from Part 1 of the planning across all funding sources. Your OVC requirement is made up of the HKID Requirement (see details below) and 85% of the DREAMS non-HKID programmed funds for all new FY 2020 funds. Additionally, due to Congressional earmarks, some of the OVC requirement must be programmed from specific funding sources, as indicated above in Table 2. The COP 2020 planned level of new funds for the OVC earmark can be above this amount; however, it cannot fall below it.

HKID Requirement: OU's COP/ROP 2020 minimum requirement for the HKID budget code is reflected in Table 3 and is a subset of the OVC earmark. Your COP/ROP 2020 HKID requirement is derived based upon the approved COP/ROP 2019 HKID level inclusive of OVC and prevention intervention for children under 19 budget codes. The COP/ROP 2020 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

Gender Based Violence (GBV): OU's COP/ROP 2020 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total ***new FY 2020*** *funding programmed to the GBV cross-cutting code. Your COP/ROP 2020 earmark is derived by using the final COP/ROP 2019 GBV earmark allocation as a baseline. The COP/ROP 2020 planned level of new FY 2020 funds for GBV can be above this amount; however, it cannot fall below it.*

*Water: OU's COP/ROP 2020 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2020 funding** programmed to the water cross-cutting code. Your COP/ROP 2020 earmark is derived by using the final COP/ROP 2019 water earmark allocation as a baseline. The COP/ROP 2020 planned level of new FY 2020 funds for water can be above this amount; however, it cannot fall below it.*

*Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal **by agency** by the end of FY20 and must meet 40% by FY19. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY20 as appropriate through their COP/ROP 2019 submission.*

COP 2020 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

All agencies in Mozambique should hold a 3 month pipeline at the end of COP/ROP 2020 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP/ROP 2019 implementation (end of FY 2020) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP/ROP 2020, decreasing the new funding amount to stay within the planning level.